NEW JERSEY

STATE HEALTH BENEFITS PROGRAM

EMPLOYEE DENTAL PLANS

MEMBER HANDBOOK

THE DENTAL EXPENSE PLAN
AND
THE DENTAL PLAN ORGANIZATIONS

Department of the Treasury

Division of Pensions and Benefits

July 2005

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INTRODUCTION

The State Health Benefits Program (SHBP) was originally established in 1961. It offers medical, prescription drug, and dental coverage to qualified public employees and retirees, and their eligible dependents. The State Health Benefits Program Act is found in the New Jersey Statutes Annotated, Title 52, Article 17.25 et.seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

The State Health Benefits Commission (SHBC) is the executive organization responsible for overseeing the State Health Benefits Program. The SHBC includes the State Treasurer as the chairperson, the Commissioner of the Department of Banking and Insurance, the Commissioner of the Department of Personnel, a State employee representative chosen by the Public Employees' Committee of the AFL-CIO, and a representative chosen by the New Jersey Education Association (NJEA), or their designated representatives. The Director of the Division of Pensions and Benefits is the Secretary to the SHBC. The Division of Pensions and Benefits, specifically the Health Benefits Bureau and the Bureau of Policy and Planning, is responsible for the daily administrative activities of the SHBP.

This booklet describes the Employee Dental Plans which consist of the Dental Expense Plan and the Dental Plan Organizations. The Employee Dental Plans are available to full-time employees of the State of New Jersey, State colleges and universities, certain independent State agencies, and adopting local government and local education employers. Before making any enrollment decision, you should carefully review the standards of eligibility and the conditions, limitations, and exclusions of the benefit coverage offered under each plan. The complete terms of Employee Dental Plans coverage are described in the Dental Expense Plan contract and the Dental Plan Organization contracts with amendments.

An online version of this handbook containing current updates is available for viewing over the Internet at: *www.state.nj.us/treasury/pensions/shbp.htm* Be sure to check the Division of Pensions and Benefits Internet home page at: *www.state.nj.us/treasury/pensions* for SHBP related forms, fact sheets, and news of any new developments affecting the benefits provided under the SHBP.

Every effort has been made to ensure the accuracy of the *Employee Dental Plans Member Handbook*, which describes the benefits provided in the contracts with the dental plans. However, State law and the New Jersey Administrative Code govern the SHBP. **If there are discrepancies between the information presented in this handbook, and the law, regulations, or contract, the latter will govern.**

If, after reading this booklet, you have any questions, comments, or suggestions regarding this material, please write to the Division of Pensions and Benefits, PO Box 295, Trenton, NJ 08625-0295, call us at (609) 292-7524, or send e-mail to: *pensions.nj@treas.state.nj.us* Refer to page 46 for information on contacting the SHBP and its related health services.

SECTION ONE

STATE HEALTH BENEFITS PROGRAM ELIGIBILITY

ACTIVE EMPLOYEE ELIGIBILITY

Eligibility for coverage is determined by the State Health Benefits Program (SHBP). Enrollments, terminations, changes to coverage, etc. must be presented through your employer to the SHBP. If you have any questions concerning eligibility provisions, you should call the Division of Pensions and Benefits' Office of Client Services at (609) 292-7524.

STATE EMPLOYEES

To be eligible for dental coverage, you must work full-time or be an appointed or an elected officer of the State of New Jersey (this includes employees of a State agency or authority and employees of a State college or university). For State employees, full-time normally requires 35 hours per week.

State part-time employees covered under Chapter 172, P.L. 2003, and State intermittent employees covered by negotiated agreements between the State of New Jersey and the Communications Workers of America (CWA) are not eligible for coverage under the Employee Dental Plans.

LOCAL EMPLOYEES

To be eligible for Employee Dental Plans local employer coverage, you must be a full-time employee or an appointed or elected officer receiving a salary from a local employer (county, municipality, county or municipal authority, board of education, etc.) that participates in the SHBP and has adopted a SHBP resolution to provide dental benefits under the Employee Dental Plans. Each participating local employer defines, in its resolution, the minimum hours required to be considered a full-time employee, but it can be no less than an average of 20 hours per week. Employment must also be for 12 months per year except for employees whose usual work schedule is 10 months per year (the standard school year).

Local part-time employees covered under Chapter 172, P.L. 2003, are not eligible for coverage under the Employee Dental Plans.

ELIGIBLE DEPENDENTS

Your eligible dependents are your spouse or eligible same-sex domestic partner (as defined on page 3) and/or your eligible unmarried children (as defined on page 3).

Spouse — This is a member of the opposite sex to whom you are legally married. A photocopy of the marriage certificate is required for enrollment.

Domestic Partner — This is a same-sex domestic partner, as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act, of any State employee, State retiree, or an eligible employee or retiree of a local public entity if the local governing body adopts a resolution to provide Chapter 246 health benefits. A photocopy of the New Jersey *Certificate of Domestic Partnership* (or a valid certification from another jurisdiction that recognizes same-sex domestic partners, civil unions, or similar same-sex relationships) is required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see your employer or Fact Sheet #71, *Benefits Under the Domestic Partnership Act,* for details).

Children — This includes your unmarried children under age 23 who live with you in a regular parent-child relationship, your children who are away at school, as well as divorced children living at home provided that they are dependent upon you for support and maintenance. If you are a single parent, divorced, or legally separated, your children who do not live with you are eligible if you are legally required to support those children — *Affidavits of Dependency* **and** legal documentation are required with enrollment forms for these cases. If a Qualified Medical Child Support Order (QMCSO) is issued for your child, the health plan of the parent named in the QMCSO will be the primary plan for that child. The employer must be notified of the QMCSO and a *NJ State Health Benefits Program Application* submitted electing coverage for the child within 60 days of the date the order was issued.

Stepchildren, foster children, legally adopted children, and children in a guardian-ward relationship are also eligible provided they live with you and are substantially dependent upon you for support and maintenance. *Affidavits of Dependency* and legal documentation are required with enrollment forms for these cases.

Coverage for an enrolled child will end when the child marries, enters into a domestic partnership, moves out of the household, turns age 23, or is no longer dependent on you for support and maintenance. Coverage for children age 23 ends on December 31 of the year in which they turn age 23 (see “COBRA Coverage” on page 4 and “Extension of Coverage Provisions” on page 7 for continuation of coverage provisions).

Dependent Children with Disabilities — If a covered child is not capable of self-support when he or she reaches age 23 due to mental illness, mental retardation, or a physical disability, he or she may be eligible for a continuance of coverage. To request continued coverage, contact the Office of Client Services at (609) 292-7524 or write to the Division of Pensions and Benefits, Health Benefits Bureau, 50 West State Street, P. O. Box 299, Trenton, New Jersey 08625 for a *Continuance for Dependent with Disabilities* form. The form and proof of the child's condition must be given to the Division no later than 31 days after the date coverage would normally end. Since coverage for children ends on December 31 of the year they turn 23, you have until January 31 to file the *Continuance for Dependent with Disabilities* form. Coverage for children with disabilities may continue only while (1) you are covered through the SHBP, and (2) the child continues to be disabled, and (3) the child is unmarried, and (4) the child remains dependent on you for support and maintenance. You will be contacted periodically to verify that the child remains eligible for continued coverage.

RETIREES

At retirement, retirees who are eligible for enrollment into the Retired Group of the SHBP may elect to enroll for coverage in the SHBP Retiree Dental Expense Plan.

For more information about this plan, see Fact Sheet #73, *Retiree Dental Expense Plan,* or the *SHBP Retiree Dental Expense Plan Member Handbook* (see page 48 for information on how to obtain these publications).

COBRA COVERAGE

CONTINUING COVERAGE WHEN IT WOULD NORMALLY END

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federally regulated law that gives employees and their eligible dependents the opportunity to remain in their employer's group coverage when they would otherwise lose coverage. COBRA coverage is available for limited time periods and the member must pay the full cost of the coverage plus an administrative fee.

Under COBRA, you may elect to continue in any or all of the coverages you had as an active employee or dependent (health, prescription drug, dental, and vision). You may also change your health or dental plan when enrolling in COBRA. You may elect to cover the same dependents that you covered while an active employee, or delete dependents from coverage — however, you cannot add dependents who were not covered while an employee except during the annual Open Enrollment period or unless a "qualifying event" (marriage, birth or adoption of a child, etc.) occurs within 60 days of the COBRA event.

The rules and plan provisions that govern COBRA coverage for the Employee Dental Expense Plans are the same as those for the SHBP medical plans, and are described in detail in the *SHBP Summary Program Description.* Please refer to the *SHBP Summary Program Description* for additional information about your rights and responsibilities under COBRA (see page 48 for information on how to obtain this publication).

SECTION TWO

EMPLOYEE DENTAL PLANS

All benefits listed in this handbook may be subject to limitations and exclusions as described in subsequent sections.

Even though a service or supply may not be described or listed in this handbook, that does not make the service or supply eligible for a benefit under this plan.

GENERAL CONDITIONS OF THE DENTAL PLANS

ENROLLMENT

Enrollment in a dental plan is optional. If you do not enroll when first eligible, you will have the option to enroll each year during the annual SHBP Open Enrollment Period.

In deciding whether to enroll and which plan to choose, you should consider the differences in out-of-pocket costs, the covered services between the Dental Expense Plan and a Dental Plan Organization, and the degree of flexibility that you may want in selecting a dentist.

Eligibility for coverage is determined by the SHBP. Enrollments, terminations, changes to coverage, etc. must be presented through your employer to the SHBP.

Limitation on Changing Dental Plans

If you choose to enroll in a dental plan, **you must remain in the dental plan you select for at least 12 months.**

Dual Dental Enrollment is Prohibited

SHBP regulations prohibit two members who are married to each other, or are eligible same-sex domestic partners, and who are both enrolled in the SHBP from enrolling under more than one of the SHBP's dental plans. An individual may belong to a dental plan as an employee or as a dependent but not as both. Furthermore, two SHBP members cannot both cover the same children as dependents under their SHBP dental plan coverage.

In cases of divorce or single parent coverage of dependents, there is no coordination of benefits under two SHBP dental plans.

Other Enrollment Information

Except as indicated above, the rules for enrollment and information on maintaining coverage in the Employee Dental Plans are the same as those for the SHBP health plans. Please refer to the *SHBP Summary Program Description* for additional information about enrollment, dates of coverage,and other coverage provisions under the SHBP.

If you have any questions concerning eligibility provisions, you should call the Division of Pensions and Benefits' Office of Client Services at (609) 292-7524.

DENTAL PLAN CHOICES

You may choose to enroll into one of two different types of dental plans:

- The **Dental Expense Plan** is a traditional indemnity plan that allows you to obtain services from any dentist. After you satisfy the $50 annual deductible (the deductible applies to non-preventive services only), you are reimbursed a percentage of the reasonable and customary charges for the services that are covered under the Dental Expense Plan. This plan is administered under a contract between the State Health Benefits Commission (SHBC) and Aetna Life Insurance Company (Aetna).
- The **Dental Plan Organizations** (DPOs) are companies that contract with a network of providers for dental services. There are several DPOs participating in the SHBP Employee Dental Plans from which you may choose. You must use providers participating with the DPO you select to receive coverage. Be sure you confirm that the dentist or dental facility you select is taking new patients and participates with the SHBP Employee Dental Plans, since DPOs also service other organizations.

LEVELS OF COVERAGE

There are four levels of coverage:

- **Single:** covers the employee only
- **Member and Spouse or eligible Domestic Partner*:** covers the employee and his or her spouse or eligible domestic partner*.
- **Parent and Child(ren):** covers the employee and all enrolled eligible children
- **Family:** covers employee, spouse or eligible domestic partner*, and all enrolled eligible children.

*See page 3 for the definition of a domestic partner.

DENTAL PLAN PREMIUMS

The cost for participation in a dental plan is shared by the State or local employer and dental plan participants. For a current list of premium rates and payroll deduction schedules, please see your benefits administrator.

State Employees

For State employees paid through the State's Centralized Payroll Unit, premium payments are made through biweekly payroll deductions.

For all other State employees, premium payments are made through a deduction schedule determined by your employer.

State employee premiums can be paid on a pre-tax basis through participation in the Premium Option Plan (POP) of the State's IRC Section 125 Program, *Tax$ave.* Participation in POP is

automatic unless you specifically decline enrollment. See “Appendix IV” on page 39 for more information on *Tax$ave.*

Note: *Tax$ave* POP members are not permitted to drop coverage within a calendar year unless a qualifying event occurs, see “Appendix IV” on page 39.

Local Government and Local Education Employees

For local employees, premium payments are made through a deduction schedule determined by your employer.

Note: The State *Tax$ave* program is not available to local employees. Contact your employer to find out if you are eligible to pay premiums on a pre-tax basis through an IRC Section 125 Program offered by your employer.

EXTENSION OF COVERAGE PROVISIONS

If Eligibility Ends While Undergoing Treatment

For both **Dental Expense Plan** and **Dental Plan Organizations:**

If coverage for you or a dependent is terminated, the coverage will be extended for 30 days following the end of the coverage in order to complete the following procedures:

- An appliance or modification of an appliance for which the impression was taken while the person was covered.
- A crown or restoration for which a tooth was prepared while the person was covered.
- Root canal therapy for which the pulp chamber was opened while the person was covered.

If DPO Participation is Terminated

If your DPO is no longer offered by the SHBP, you will be given the opportunity to join another dental plan provided by the SHBP Employee Dental Plans. For services that have already begun prior to plan termination, including a full course of orthodontic treatment, coverage for those services for you and your dependents will be extended at no additional cost to you except for the remaining portion of any copayment that has not yet been paid.

Continuation Under COBRA

See page 4 for additional continuation of coverage provisions available under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

SPECIAL PROVISIONS OF THE SHBP

COORDINATION OF BENEFITS WITH OTHER INSURANCE PLANS

There is no coordination of benefits between the two SHBP dental plans because no individual is eligible for coverage in more than one SHBP dental plan.

If you and your dependents are also covered for dental expenses by other plans, certain rules apply that determine which plan provides the primary coverage and how much each plan will reimburse you. The purpose of these rules is to prevent a combined reimbursement from both plans that exceeds the expenses that you actually incur. Although there may be special cases not described here, the usual determination of which plan provides primary coverage is as follows:

- The employee's primary dental coverage is provided by the Dental Expense Plan or the Dental Plan Organization.
- If your spouse/same-sex domestic partner is enrolled as your dependent and is also covered by a dental plan through his or her employer, your spouse/same-sex domestic partner's primary coverage is through the dental plan offered by his or her employer.
- If your children are enrolled as dependents in your plan and your spouse/same-sex domestic partner's plan, their primary coverage is provided by the dental plan of the parent whose birthday falls earlier in the year. If your spouse/same-sex domestic partner's plan does not follow this rule, then the rule in the other program will determine the order of benefits.
- In the case of a separation, divorce, or parents who are not married, the primary coverage for a child is provided in this order: by the plan of the parent who is legally responsible for the dental expenses of the child; by the plan of the parent with custody of the child; by the plan of the spouse/same-sex domestic partner of the parent with custody of the child; or by the plan of the non-custodial parent.

THIRD PARTY LIABILITY

Repayment Agreement

If you have received benefits from your dental plan for services that are either auto-related or work-related, the SHBP Employee Dental Plans has the right to recover those payments. This means that if your dental expenses are also reimbursed by a third party through a settlement, satisfied by a judgement, or other means, you are required to return any benefits paid for illness or injury to the SHBP. The repayment will only be equal to the amount paid by the SHBP.

This provision is binding whether the payment received from the third party is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, whether or not the third party has admitted liability for the payment.

Recovery Right

You are required to cooperate with the SHBP Employee Dental Plans in recovering any benefits paid by the plan that may also be payable by a third party. The SHBP may:

- Assume your right to receive payment for benefits from the third party;
- Require you to provide all information and sign and return all documents necessary to exercise the SHBP's rights under this provision, before any benefits are provided under your group's policy; or
- Require you to give testimony, answer interrogatories, attend depositions, and comply with all legal actions which the SHBP may find necessary to recover money from all sources when a third party may be responsible for damages or injuries.

HIPAA PRIVACY

The SHBP makes every effort to safeguard the health information of its members and complies with the privacy provisions of the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. HIPAA requires medical and dental plans to maintain the privacy of any personal information relating to its members' physical or mental health. See “Appendix V” on page 42 for the State Health Benefits Program's *Notice of Privacy Practices.*

AUDIT OF DEPENDENT COVERAGE

Periodically, the SHBP performs an audit using a random sample of members to determine if dependents are eligible under plan provisions. Proof of dependency such as a marriage certificate or birth certificate is required. Coverage for ineligible dependents will be terminated. Failure to respond to the audit will result in the termination from coverage of dependent(s).

SECTION THREE

THE DENTAL EXPENSE PLAN

The Dental Expense Plan is an indemnity plan that reimburses for a portion of the expenses incurred for dental care provided by dentists or physicians licensed to perform dental services in the state in which they are practicing. Not all dental services are eligible for reimbursement, and some services are eligible only up to a limited amount. (For example, orthodontic services are reimbursed differently than other services.) Diagnostic/preventive and orthodontic services, are not subject to the deductible. For all other services, an annual deductible amount must be met before benefits are payable. You are responsible for making the full payment of all charges to your dentist.

The Dental Expense Plan has been established by the State as a self-funded plan. The State currently contracts with Aetna Dental to act as the administrative agent for the Dental Expense Plan.

As a Dental Expense Plan member, you may be able to take advantage of a special Aetna network of participating dental providers. In this network, participating dental providers contract with Aetna for a discounted fee schedule. When using a participating dental provider, you only pay the provider any applicable deductible and the appropriate coinsurance based on the discounted fee, thereby reducing your out-of-pocket cost. In many cases the participating dental provider will submit the claims directly to Aetna, eliminating the necessity of filing claim forms. To find out if your provider participates in the discounted network, call Aetna at 1-877-238-6200 or log onto Aetna's online provider directory, DocFind, at: *www.aetna.com*

Annual Deductible

Diagnostic/Preventive and **Orthodontic** services are not subject to a deductible amount. For other services, the first $50 of covered expenses that you or your dependent(s) incur in a calendar year is not eligible for reimbursement. However, if there are four or more members of your family in the Dental Expense Plan, no additional deductibles are charged after any three members have each met their $50 deductible.

Reasonable and Customary Charges

The Dental Expense Plan covers only that part of a provider's charge for a service or supply that is reasonable and customary. Generally speaking, a charge by your dentist, or by any other provider of services or supplies, is considered reasonable and customary if it doesn't exceed the prevailing charge for the same service or supply made by similar providers in the same geographic area. It may differ from the actual amount that your dentist charges. You are responsible for the amount the dentist charges above the reasonable and customary allowances.

Levels of Reimbursement

After a covered individual meets his or her $50 deductible (if applicable), the costs of all other eligible services for that person are reimbursed at a percentage of the reasonable and customary charge for the service (except where certain limits apply and subject to benefit maximums).

The reimbursement percentages are as follows:

- **100 percent Diagnostic and Preventive Services** (No deductible applicable)
- **80 percent Basic Services**
- **65 percent Major Restorative Services**
- **50 percent Periodontic and Prosthodontic Services**
- **50 percent Orthodontic Services** (No deductible applicable; separate $1000 lifetime benefit maximum)

Note: When you use an Aetna participating dental provider, plan benefits are based on the applicable negotiated fee.

COVERED SERVICES

A general description of each category of service is provided below. Refer to "Services that are Eligible for Reimbursement" on page 15 for any limitations that may apply to these services.

Diagnostic and Preventive Services are precautionary services and are intended to maintain oral health and reduce the effects of tooth decay or gum disease which could lead to an increased need for more costly restorative services. They include the following:

- Oral Evaluations (includes comprehensive, periodic, limited, and specialist oral evaluations)
- Prophylaxis (cleaning of the teeth, including scaling and polishing procedures)
- Fluoride Treatments (topical application of fluoride for children under age 19)
- X-rays (limitations may apply)
- Laboratory and other Diagnostic Tests

Basic Services include:

- Emergency Treatment (Palliative only)
- Space Maintainers (i.e., passive appliances — can be fixed or removable)
- Simple Extractions
- Surgical Extractions
- Oral Surgery
- Anesthesia Services
- Basic Restorations (i.e., amalgam restorations and resin restorations)
- Endodontics (i.e., treatment of diseases of the dental pulp, including root canal and associated therapy)
- Repairs to removable dentures

Major Restorative Services include those services that restore existing teeth. These services are utilized only if a tooth cannot be restored with an amalgam, acrylic, synthetic porcelain, or composite filling restoration. Inlays, onlays, and crowns are typical examples of major restorative services.

Periodontal Services include those services involving the maintenance, reconstruction, regeneration, and treatment of the supporting structures surrounding teeth, including bone, gum tissue, and root surfaces.

Prosthodontic Services include both removable and fixed dentures (bridges) replacing missing teeth.

Orthodontic Services include services to correct abnormalities in tooth position (malposition) or abnormal bite (malocclusion), using appliances such as retainers or braces (see page 16).

Annual and Lifetime Benefit Maximums

The most the Dental Expense Plan will pay for any one person in any one calendar year is $3,000. This maximum applies to all eligible services except orthodontic, which has a separate $1,000 lifetime benefit maximum.

DENTAL BENEFITS AT A GLANCE

Annual Deductible Amount of covered expenses you must pay each calendar year, before the Dental Expense Plan begins to pay benefits	Diagnostic/Preventive Services: $0 Orthodontic Services: $0 Other Services: $50 per individual; $150 per family (3 members at $50 each)
Benefit Percentage Percent of covered expenses paid by the Dental Expense Plan, after any applicable deductibles have been met, subject to reasonable and customary allowances	100% Diagnostic/Preventive Services 80% Basic Restorative Services 65% Major Restorative Services 50% Periodontic and Prosthodontic Services
Benefit Maximum	$3,000 Annual
Orthodontic Services	50% to $1,000 lifetime maximum (not subject to deductible and does not count towards the annual benefit maximum)

ADDITIONAL PROVISIONS OF THE DENTAL EXPENSE PLAN

How Payments Are Made

Normally, reimbursements will be made to the Dental Expense Plan subscriber. The Dental Expense plan subscriber may, however, authorize Aetna to send the reimbursement directly to the dental provider by completing the appropriate part of the claim form.

Additionally, whenever a law or court order requires the payment of dental expense benefits under the Dental Expense Plan to be made to a person or facility other than the Dental Expense Plan subscriber, the payment will be made to that person or facility upon proper notification (letter and a copy of the order/law).

Filing Deadline — Proof of Loss

Aetna must be given written proof that a dental service has been performed for which a claim is made under the coverage. This proof must cover the occurrence, character, and extent of the service. It must be furnished within one year and 90 days of the end of the calendar year in which the service was incurred. For example, if a service were incurred in the year 2005, you would have until March 31, 2007, to file the claim.

A claim will not be considered valid unless proof of the service is furnished within the time limit indicated above. If it is not possible for you to provide proof within the time limit, the claim may be considered valid upon appeal if the reason the proof was not provided in a timely basis was reasonable.

Itemized Bills are Necessary

You must obtain itemized bills from the providers of services for all dental expenses. The itemized bills must include the following:

- Name and address of provider
- Provider's tax identification number
- Name of patient
- Subscriber’s identification number
- Date of service
- Type of service
- Procedure code (CDT — 2005 Code)
- Charge for each service

Predetermination of Benefits

Predetermination is voluntary and allows you to know what services are covered and what payments will be made for treatment before the work is done. If you or one of your dependents are likely to incur dental expenses over $300, it is strongly recommended that you ask your dentist to file for predetermination of benefits.

This feature of the Dental Expense Plan ensures that both you and the dentist will know in advance what part of the dentist's charges the Dental Expense Plan will pay. If possible, treatment should be completed within 90 days of receiving the approved predetermination.

The predetermination of benefits provision of the Dental Expense Plan is important, because under the alternative procedures provision (see "Alternative Procedures" below), Aetna has the right to pay the reasonable and customary allowance for the method of treatment that is proper and is economically sound.

How Predetermination of Benefits Works — Your dentist submits a treatment plan and Aetna determines the amount the Dental Expense Plan will pay and informs you and the dentist of its payment decision. You and your dentist should discuss the predetermination before the work is started.

Predetermination of benefits will help you avoid surprises. Most dentists are familiar with predetermination procedures, but if not, they should call Aetna at 1-877-238-6200. If your dentist submits a treatment plan for predetermination of benefits and then alters the course of treatment, Aetna will adjust its payments accordingly. If the dentist makes a major change in the treatment plan, he or she should send in a revised plan.

Alternative Procedures

Usually there are several ways to treat a particular dental problem. Payment will be based on the least costly treatment as determined by Aetna so long as the treatment meets acceptable dental standards. If you and the dentist decide you want a more costly treatment method, you are responsible for the charges beyond those for the less costly, appropriate treatment.

SERVICES THAT ARE ELIGIBLE FOR REIMBURSEMENT

Even though a service or supply may not be described or listed in this handbook, that does not make the service or supply eligible for a benefit under this plan.

- Oral evaluations (limited to twice in a Calendar year). Emergency or limited oral evaluations are limited to once in a Calendar year, per patient — covered at 100 percent of the reasonable and customary charges (see page 10).
- X-rays (horizontal bitewing X-rays limited to two series of up to 4 films in a Calendar year; vertical bitewing X-rays limited to two series of up to 8 films per Calendar year; set of full mouth or panoramic X-rays limited to once per 36-month interval; no more than 18 films per set of full mouth periapical X-rays).
- Oral prophylaxis, including scaling (not including scaling performed by a periodontist) and polishing (limited to twice in a Calendar year).
- Topical application of fluoride for children under age 19 limited to twice in a Calendar year.
- Sealants (limited to once per lifetime for permanent molars of eligible dependent children under the age of 19 years).
- Prosthodontic procedures (the replacement of an existing fixed or removable prosthetic appliance is covered only after a 5-year period measured from the date on which the appliance was previously placed).
- Periodontic procedures (reimbursement for periodontal surgical procedures and follow-up maintenance, usually provided for a specific quadrant, is limited to one surgical-type procedure every 36 months). Reimbursement for periodontal scaling and root planing procedures per specific quadrant is limited to one procedure per 12-month interval.
- Restorative procedures, including fillings, inlays, onlays, and crowns (the replacement of a crown is covered only after a 5-year period measured from the date on which the crown was previously placed).
- Emergency palliative treatment.
- Extractions of teeth.
- Endodontic services, such as pulpotomy and root canal therapy.
- Space maintainers.
- Oral surgery for surgical extractions, treatment of fractures, removal of lesions of the mouth, alveolectomy, and biopsy of hard and soft tissue.
- Apicoectomy.
- General anesthesia (including conscious sedation coverage) when medically necessary and in connection with covered oral and periodontal surgical procedures.

ORTHODONTIC SERVICES THAT ARE ELIGIBLE FOR REIMBURSEMENT

Certain charges for orthodontic procedures are eligible if:

- You have been a full-time employee for at least 10 months.
- The orthodontic treatment is for a child covered under the Dental Expense Plan who is less than 19 years old.
- The procedure involves the use of active appliances to move teeth in order to correct the faulty position of teeth (malposition) or abnormal bite (malocclusion).
- The service or supply is part of a treatment plan submitted by the dentist and approved by Aetna with an estimate of the benefits that are payable.
- The service or supply is furnished before the end of the estimated duration of the treatment as recorded in the treatment plan.
- An active appliance for the procedure is inserted while the person is eligible for benefits in this program.

Orthodontic Benefits

Eligible orthodontic services will be covered at 50 percent, up to a lifetime benefit maximum of $1,000. There is no deductible for orthodontic services.

Note: See page 18 for “Orthodontic Charges that are Not Eligible Under the Dental Expense Plan”.

SERVICES THAT ARE NOT ELIGIBLE FOR REIMBURSEMENT

- Any orthodontic service prior to the employee attaining 10 months of employment or for any member over 19 years of age. (See the separate section for special coverage for orthodontic services on page 16.)
- Gold restorations other than crowns, inlays, and onlays.
- Any service or item not reasonably necessary for the dental care of the patient.
- Endosteal, subperiosteal, and transosteal tooth implants.
- Protective devices such as athletic mouth guards, plaque control, or myofunctional therapy.
- Services and/or appliances that are for the primary purpose of altering vertical dimension (change the way natural teeth meet), including full mouth rehabilitation (crowning all or most of the teeth), splinting teeth with crowns, fillings, appliances, or any method or service that restores occlusion or incisal tooth structure lost from attrition, erosion, abrasion, or any other cause.
- Crowns, inlays, and onlays if used in splinting procedures during periodontal treatment.
- A service for cosmetic purposes.
- Any charge for a supply that is normally for home use such as toothpaste, toothbrushes, water-pick, or mouthwash.
- A dental examination when required as a condition of employment by an employer, a government agency, or the terms of a labor agreement.
- Charges for services that are not reasonably necessary made to produce a professionally acceptable result.
- A service or supply due to a war or any act of war.
- A service not furnished by a dentist or physician licensed to provide the dental service, except for a service performed by a licensed dental hygienist under the direction of a dentist.
- A service rendered by a provider that is beyond the scope of the provider's license.
- A charge made by a dentist for a failure of the patient to keep an appointment.
- A charge for the completion of any claim forms.
- A charge in connection with any procedure started before the patient was eligible for reimbursement in this program; except that a procedure will not have been considered to have started with an oral prophylaxis or a diagnostic procedure.
- Any service or supply other than those specifically covered under this program.
- Hospitalization.
- Experimental procedures.

- A service covered under any medical, surgical, or major medical plan (including a Health Maintenance Organization — HMO) provided by the employer.
- A service made available to a covered individual or financed by the federal, state, or local government. This includes the federal Medicare program and any similar federal program, any Workers' Compensation law or similar law, any automobile no-fault law, or any other program or law under which the covered individual is, or could be, covered. The exclusion is applicable whether or not the covered individual receives the service, makes a claim or receives compensation for the service, or receives a recovery from a third party for damages.
- Any charge incurred after the patient is no longer covered, except in the case of an Extension of Coverage (see page 7).
- Any charge for a service that is more than the reasonable and customary dental charge.
- Any charge for a service rendered by a member of the patient's immediate family (including you, your spouse or eligible same-sex domestic partner, your child, brother, sister, or parent of you or your spouse or eligible same-sex domestic partner).
- Charges for sterilization or asepsis.

Orthodontic Charges that are Not Eligible Under the Dental Expense Plan

- Charges that are eligible for coverage under the regular dental care portion of the program.
- Charges for an orthodontic procedure started prior to the day on which the person became covered under the program or eligible for orthodontic benefits.
- Charges not reasonably necessary for orthodontic care.
- Any charges incurred for orthodontic procedures or treatment begun on or after the date the person attains age 19.

SECTION FOUR

THE DENTAL PLAN ORGANIZATIONS

A Dental Plan Organization (DPO) is similar to a medical Health Maintenance Organization (HMO) program. The full cost for most services is prepaid to your dentist, but certain services require an additional copayment from you. Also, if you choose a more expensive treatment than deemed appropriate by your dental provider, you must pay the extra cost. Further, you will not be covered for services if you go to a dentist who is not a member of your DPO, unless referred by your DPO dentist. There are many Dental Plan Organizations included among the State dental plans (see page 38). Among these organizations, there are two types of plans – Dental Center and Individual Practice Associations (IPA).

- Dental Centers employ a group of dentists and technicians who are located at a central office. In a Dental Center Plan, you do not have the option to select a particular dentist unless permitted by the Dental Center. However, some DPOs offer both a Dental Center and a list of participating dentists, thereby giving you the option of selecting a center or a particular dentist.
- An Individual Practice Association (IPA) consists of a network of participating dentists who work in their own offices. If you choose an IPA, you must select a specific dentist in the IPA who will treat you and your dependents.

The DPO dentist is responsible for providing all of the services that are listed as covered in this booklet. If the participating dentist that you have selected does not provide a specific service, then the DPO must refer you to another participating dentist located within 10 miles of your dentist's office (or 20 miles for orthodontic service). If you agree, the DPO may also refer you to a dentist located beyond these limits.

If the DPO has no participating dentist who can provide the service in your geographical area, then the DPO must refer you to a nonparticipating dentist within the 10 or 20-mile limit. If there is no dentist within this area, then you must be referred to the dentist closest to your dentist's office.

If the DPO dentist refers you to another dentist and that referral is approved by the DPO, then you will have the same coverage for the service as if you had been treated by your dentist. However, if you select an outside dentist on your own, the service you receive will not be covered.

CONSIDERATIONS IN CHOOSING A DPO

- Obtain a list of DPOs and participating dentists from your benefits administrator. If you choose a dentist rather than a Dental Center, check with the DPO and the dentist to be sure that the dentist is a member of the DPO, services SHBP members, and will accept you as a new patient.
- If you choose a dentist, you should also check with the dentist to make sure that he or she plans to stay in the DPO. If the dentist leaves, you will then have to select another dentist in that DPO.

- You should also check to determine that the DPO dentist or center could serve the needs of your entire family and whether the days and hours of operation are convenient for you and your family.
- If your dentist leaves the DPO, and there are no other dentists in the DPO within 30 miles of your home, you may switch to another dental plan (either another DPO or the Dental Expense Plan).

COVERED SERVICES

The following is a list of covered services and, if applicable, required copayments. Copayments are your portion of the cost for the service.

Codes	Description of Covered Services	Copayments
D0100-D0999 I. DIAGNOSTIC		
Clinical Oral Evaluations		
(Oral evaluations are limited to two in a Calendar year. Emergency or limited oral evaluations are covered, limited to one evaluation per patient, per dentist, per Calendar year. There are no copayments for diagnostic services.)		
D0120	Periodic Oral Evaluation	$ 0
D0140	Limited Oral Evaluation — Problem Focused	$ 0
D0150	Comprehensive Oral Evaluation — New or Established Patient	$ 0
D0160	Detailed and Extensive Oral Evaluation — Problem Focused, by Report	$ 0
Radiographs		
(Bitewing X-rays are limited to two series of up to 4 films in a Calendar year; set of full mouth X-rays are limited to once per 36 month interval; no more than 18 films per set of mouth X-rays)		
D0210	Intraoral — Complete Series Including Bitewings	$ 0
D0220	Intraoral — Periapical — First Film	$ 0
D0230	Intraoral — Periapical — Each Additional Film	$ 0
D0240	Intraoral — Occlusal Film	$ 0
D0250	Extraoral — First Film	$ 0
D0260	Extraoral — Each Additional Film	$ 0
D0270	Bitewings — Single Film	$ 0
D0272	Bitewings — Two Films	$ 0
D0274	Bitewings — Four Films	$ 0
D0277	Vertical Bitewings — Eight Films	$ 0
D0290	Posterior — Anterior or Lateral Skull and Facial Bone Survey Film	$ 0
D0330	Panoramic Film	$ 0
D0340	Cephalometric Film	$ 0

Tests and Laboratory Examinations

D0415	Collection of Microorganisms for Culture and Sensitivity	$ 0
D0416	Viral Culture	$ 0
D0421	Genetic Test for Susceptibility to Oral Diseases	$ 0
D0425	Caries Susceptibility Tests	$ 0
D0460	Pulp Vitality Tests	$ 0
D0470	Diagnostic Casts	$ 0

D1000-D1999 II. PREVENTIVE

Dental Prophylaxis

(Limited to two in a Calendar year)

D1110	Prophylaxis — Adult	$ 0
D1120	Prophylaxis — Child	$ 0

Topical Fluoride Treatment *(Office Procedure)*

(Limited to two in a Calendar year, and only for eligible dependent children under the age of 19 years)

D1201	Topical Application of Flouride (Including Prophylaxis) — Child	$ 0
D1203	Topical Application of Flouride (Prophylaxis Not Included) — Child	$ 0
D1204	Topical Application of Flouride (Prophylaxis Not Included) — Adult	$ 0
D1205	Topical Application of Flouride (Including Prophylaxis) — Adult	$ 0

Other Preventive Services

(Sealants are limited to once per lifetime for permanent molars of eligible dependent children under the age of 19 years)

D1330	Oral Hygiene Instruction	$ 0
D1351	Sealant — Per Tooth	$ 0

Space Maintenance *(Passive Appliances*)

D1510	Space Maintainer — Fixed — Unilateral	$ 0
D1515	Space Maintainer — Fixed — Bilateral	$ 0
D1520	Space Maintainer — Removable — Unilateral	$ 0
D1525	Space Maintainer — Removable — Bilateral	$ 0
D1550	Recementation of Space Maintainer	$ 0

D2000-D2999 III. RESTORATIVE

(The replacement of a crown is covered only after a 5 year period measured from the date on which the crown was previously placed)

Amalgam Restorations *(Including Polishing)*

D2140	Amalgam — One Surface — Primary or Permanent	$ 0
D2150	Amalgam — Two Surfaces — Primary or Permanent	$ 0
D2160	Amalgam — Three Surfaces — Primary or Permanent	$ 0
D2161	Amalgam — Four or More Surfaces — Primary or Permanent	$ 0

Resin Restorations

D2330	Resin-Based Composite — One Surface — Anterior	$ 0
D2331	Resin-Based Composite — Two Surfaces — Anterior	$ 0
D2332	Resin-Based Composite — Three Surfaces — Anterior	$ 0
D2335	Resin-Based Composite — Four or more Surfaces or Involving Incisal Angle — Anterior	$ 0
D2390	Resin-Based Composite Crown — Anterior	$ 35
D2391	Resin-Based Composite — One Surface — Posterior	$ 15
D2392	Resin-Based Composite — Two Surfaces — Posterior	$ 25
D2393	Resin-Based Composite — Three Surfaces — Posterior	$ 35
D2394	Resin-Based Composite — Four or More Surfaces — Posterior	$ 45

Inlay/Onlay Restorations

D2510	Inlay — Metallic — One Surface	$ 100
D2520	Inlay — Metallic — Two Surfaces	$ 100
D2530	Inlay — Metallic — Three or more Surfaces	$ 100
D2542	Onlay — Metallic — Two Surfaces	$ 100
D2543	Onlay — Metallic — Three Surfaces	$ 100
D2544	Onlay — Metallic — Four or More Surfaces	$ 100
D2610	Inlay — Porcelain/Ceramic — One Surface	$ 115
D2620	Inlay — Porcelain/Ceramic — Two Surfaces	$ 115
D2630	Inlay — Porcelain/Ceramic — Three or More Surfaces	$ 115
D2642	Onlay — Porcelain/Ceramic — Two Surfaces	$ 115
D2643	Onlay — Porcelain/Ceramic — Three Surfaces	$ 115
D2644	Onlay — Porcelain/Ceramic — Four or More Surfaces	$ 115
D2650	Inlay — Resin-Based Composite — One Surface	$ 115
D2651	Inlay — Resin-Based Composite — Two Surfaces	$ 115
D2652	Inlay — Resin-Based Composite — Three or More Surfaces	$ 115
D2662	Onlay — Resin-Based Composite — Two Surfaces	$ 115
D2663	Onlay — Resin-Based Composite — Three Surfaces	$ 115
D2664	Onlay — Resin-Based Composite — Four or more Surfaces	$ 115

Crowns — Single Restorations Only

D2710	Crown — Resin-Based Composite *(Indirect)* *(see note on page 23)*	$ 115
D2720	Crown — Resin with High Noble Metal	$ 150
D2721	Crown — Resin with Predominantly Base Metal	$ 150
D2722	Crown — Resin with Noble Metal	$ 150
D2740	Crown — Porcelain/Ceramic Substrate	$ 200
D2750	Crown — Porcelain Fused to High Noble Metal	$ 225
D2751	Crown — Porcelain Fused to Predominantly Base Metal	$ 200
D2752	Crown — Porcelain Fused to Noble Metal	$ 200
D2780	Crown — 3/4 Cast High Noble Metal	$ 225
D2781	Crown — 3/4 Cast Predominantly Base Metal	$ 200
D2790	Crown — Full Cast High Noble Metal	$ 225
D2791	Crown — Full Cast Predominantly Base Metal	$ 200
D2792	Crown — Full Cast Noble Metal	$ 200
D2794	Crown — Titanium	$ 225

Other Restorative Services

D2910	Recement Inlay, Onlay, or Partial Coverage Restoration	$ 0
D2915	Recement Cast or Prefabricated Post and Core	$ 0
D2920	Recement Crown	$ 0
D2930	Prefabricated Stainless Steel Crown — Primary Tooth	$ 35
D2931	Prefabricated Stainless Steel Crown — Permanent Tooth	$ 35
D2932	Prefabricated Resin Crown	$ 35
D2933	Prefabricated Stainless Steel Crown with Resin Window	$ 35
D2934	Prefabricated Esthetic Coated Stainless Steel Crown — Primary Tooth	$ 35
D2940	Sedative Fillings	$ 0
D2950	Core Buildup, Including any Pins	$ 0
D2951	Pin Retention — Per Tooth in Addition to Restoration	$ 0
D2952	Cast Post and Core in Addition to Crown	$ 40
D2954	Prefabricated Post and Core in Addition to Crown	$ 40
D2955	Post Removal *(Not in Conjunction with Endodontic Therapy)*	$ 0
D2971	Additional Procedures to Construct New Crown Under Existing Partial Denture Framework	$ 0
D2980	Crown Repair — By Report	$ 0

Note: There is no copayment for procedure D2710 when performed in conjunction with a permanent crown on the same tooth.

D3000-D3999 IV. ENDODONTICS

Pulp Capping

D3110	Pulp Capping — Direct — Excluding Final Restoration	$ 0
D3120	Pulp Capping — Indirect — Excluding Final Restoration	$ 0

Pulpotomy

D3220	Therapeutic Pulpotomy — Excluding Final Restoration	$ 25

Endodontic Therapy on Primary Teeth

D3230	Pulpal Therapy *(Resorbable Filling)* — Anterior-Primary Tooth — Excluding Final Restoration	$ 20
D3240	Pulpal Therapy *(Resorbable Filling)* — Posterior-Primary Tooth — Excluding Final Restoration	$ 20

Endodontic Therapy

D3310	Anterior *(Excluding Final Restoration)*	$ 100
D3320	Bicuspid *(Excluding Final Restoration)*	$ 125
D3330	Molar *(Excluding Final Restoration)*	$ 150

Endodontic Retreatment

D3346	Retreatment of Previous Root Canal Therapy — Anterior	$ 125
D3347	Retreatment of Previous Root Canal Therapy — Bicuspid	$ 150
D3348	Retreatment of Previous Root Canal Therapyl — Molar	$ 175

Apexification/Recalcification Procedures

D3351	Apexification/Recalcification — Initial Visit	$ 35
D3352	Apexification/Recalcification — Interim Medication Replacement	$ 35
D3353	Apexification/Recalcification — Final Visit	$ 35

Apicoectomy/Periapical Services

D3410	Apicoectomy/Periradicular Surgical — Anterior	$ 90
D3421	Apicoectomy/Periradicular Surgical — Bicuspid First Root	$ 90
D3425	Apicoectomy/Periradicular Surgical — Molar First Root	$ 90
D3426	Apicoectomy/Periradicular Surgical — Each Additional Root	$ 40
D3430	Retrograde Filling — Per Root	$ 20
D3450	Root Amputation — Per Root	$ 40

Other Endodontic Procedures

D3910	Surgical Procedure for Isolation of Tooth with Rubber Dam	$ 0
D3920	Hemisection *(Including any Root Removal)*, Not Including Root Canal Therapy	$ 60

D4000-D4999 V. PERIODONTICS

(Coverage for surgical periodontal procedures, excluding scaling and root planing, is limited to one surgical periodontal treatment per quadrant every 36 months; coverage for scaling and root planing is limited to one nonsurgical periodontal treatment per quadrant every 12 months)

Surgical Services

D4210	Gingivectomy/Gingivoplasty — Four or More Contiguous Teeth or Bounded Teeth Spaces per Quadrant	$ 85
D4211	Gingivectomy or Gingivoplasty — One to Three Contiguous Teeth or Bounded Teeth Spaces per Quadrant	$ 30
D4240	Gingival Flap Procedure Including Root Planing — Four or More Contiguous Teeth or Bounded Teeth Spaces per Quadrant	$ 90
D4241	Gingival Flap Procedure Including Root Planing — One to Three Contiguous Teeth or Bounded Teeth Spaces per Quadrant	$ 60
D4245	Apically Positioned Flap	$ 90
D4249	Clinical Crown Lengthening — Hard Tissue	$ 90
D4260	Osseous Surgery *(Including Flap Entry and Closure)* — Four or More Contiguous Teeth or Bounded Teeth Spaces per Quadrant	$ 175
D4261	Osseous Surgery *(Including Flap Entry and Closure)* — One to Three Contiguous Teeth or Bounded Teeth Spaces per Quadrant	$ 100
D4263	Bone Replacement Graft — First Site in Quadrant	$ 100
D4264	Bone Replacement Graft — Each Addition Site in Quadrant	$ 50
D4266	Guided Tissue Regeneration — Resorbable Barrier per Site	$ 90
D4267	Guided Tissue Regeneration — Non-resorbable Barrier per Site	$ 90

D4270	Pedicle Soft Tissue Graft Procedure	$ 175
D4271	Free Soft Tissue Graft Procedure *(Including Donor Site Surgery)*	$ 175
D4273	Subepithelial Connective Tissue Graft Procedure — per Tooth	$ 175
D4274	Distal or Proximal Wedge Procedure *(When Not Performed in Conjunction with Surgical Procedures in the Same Anatomical Area)*	$ 40
D4275	Soft Tissue Allograft	$ 175
D4276	Combined Connective Tissue and Double Pedicle Graft — Per Tooth	$ 175

Non-Surgical Periodontal Services

D4320	Provisional Splinting — Intracoronal	$ 0
D4321	Provisional Splinting — Extracoronal	$ 0
D4341	Periodontal Scaling and Root Planing — Four or More Teeth per Quadrant	$ 55
D4342	Periodontal Scaling or Root Planing — One to Three Teeth per Quadrant	$ 40
D4355	Full Mouth Debridement to Enable Comprehensive Periodontal Evaluation and Diagnosis	$ 55

Other Periodontal Services

D4910	Periodontal Maintenance	$ 30
D4920	Unscheduled Dressing Change *(By Someone Other than Treating Dentist)*	$ 0

D5000-D5999 VI. PROSTHODONTICS (REMOVABLE)

(The replacement of an existing removable prosthetic appliance is covered only after a 5 year period measured from the date on which the appliance was previously placed)

Complete Dentures *(Including Routine Post Delivery Care)*

D5110	Complete Denture — Maxillary	$ 250
D5120	Complete Denture — Mandibular	$ 250
D5130	Immediate Denture — Maxillary	$ 275
D5140	Immediate Denture — Mandibular	$ 275

Partial Dentures *(Including Routine Post Delivery Care)*

D5211	Maxillary Partial Denture — Resin Base *(Including any Conventional Clasps, Rests, and Teeth)*	$ 250
D5212	Mandibular Partial Denture — Resin Base *(Including any Conventional Clasps, Rests, and Teeth)*	$ 250
D5213	Maxillary Partial Denture — Cast Metal Framework w/Resin Denture Bases *(Including any Conventional Clasps, Rests, and Teeth)*	$ 275
D5214	Mandibular Partial Denture — Cast Metal Framework w/Resin Denture Bases *(Including any Conventional Clasps, Rests, and Teeth)*	$ 275

D5225	Maxillary Partial Denture — Flexible Base *(Including any Clasps, Rests, and Teeth)*	$ 300
D5226	Mandibular Partial Denture — Flexible Base *(Including any Clasps, Rests, and Teeth)*	$ 300
D5281	Removable Unilateral Partial Denture — One Piece Cast Metal *(Including Clasps and Teeth)*	$ 125

Adjustments to Removable Prostheses

D5410	Adjust Complete Denture — Maxillary	$ 0
D5411	Adjust Complete Denture — Mandibular	$ 0
D5421	Adjust Partial Denture — Maxillary	$ 0
D5422	Adjust Partial Denture — Mandibular	$ 0

Repairs to Complete Dentures

D5510	Repair Broken Complete Denture Base	$ 35
D5520	Replace Missing or Broken Teeth — Complete Denture — Each Tooth	$ 35

Repairs to Partial Dentures

D5610	Repair Resin Denture Base	$ 35
D5620	Repair Cast Framework	$ 35
D5630	Repair or Replace Broken Clasp	$ 35
D5640	Replace Broken Teeth — Per Tooth	$ 35
D5650	Add Tooth to Existing Partial Denture	$ 35
D5660	Add Clasp to Existing Partial Denture	$ 35

Denture Rebase Procedures

D5710	Rebase Complete Maxilary Denture	$ 85
D5711	Rebase Complete Mandibular Denture	$ 85
D5720	Rebase Maxillary Partial Denture	$ 85
D5721	Rebase Mandibular Partial Denture	$ 85

Denture Reline Procedures

D5730	Reline Complete Maxillary Denture — Chairside	$ 40
D5731	Reline Complete Mandibular Denture — Chairside	$ 40
D5740	Reline Maxillary Partial Denture — Chairside	$ 40
D5741	Reline Mandibular Partial Denture — Chairside	$ 40
D5750	Reline Complete Maxillary Denture — *(Lab Process)*	$ 40
D5751	Reline Complete Mandibular Denture — *(Lab Process)*	$ 40
D5760	Reline Maxillary Partial Denture — *(Lab Process)*	$ 40
D5761	Reline Mandibular Partial Denture — *(Lab Process)*	$ 40

Other Removable Prosthetic Services

D5810	Interim Complete Denture *(Maxillary)*	$ 95
D5811	Interim Complete Denture *(Mandibular)*	$ 95
D5820	Interim Partial Denture *(Maxillary)*	$ 65
D5821	Interim Partial Denture *(Mandibular)*	$ 65
D5850	Tissue Conditioning *(Maxillary)*	$ 15
D5851	Tissue Conditioning *(Mandibular)*	$ 15

D6200-D6999 IX. PROSTHODONTICS, FIXED

Fixed Partial Denture Pontics

D6210	Pontic — Cast High Noble Metal	$ 225
D6211	Pontic — Cast Predominantly Base Metal	$ 200
D6212	Pontic — Cast Noble Metal	$ 200
D6214	Pontic — Titanium	$ 225
D6240	Pontic — Porcelain Fused to High Noble Metal	$ 225
D6241	Pontic — Porcelain Fused to Predominantly Base Metal	$ 200
D6242	Pontic — Porcelain Fused to Noble Metal	$ 200
D6245	Pontic — Porcelain/Ceramic	$ 200
D6250	Pontic — Resin with High Noble Metal	$ 150
D6251	Pontic — Resin with Predominantly Base Metal	$ 150
D6252	Pontic — Resin with Noble Metal	$ 150

Fixed Partial Denture Retainers — Inlays/Onlays

D6545	Retainer — Cast Metal for Resin Bonded Fixed Prosthesis	$ 100
D6602	Inlay — Cast High Noble Metal — Two Surfaces	$ 175
D6603	Inlay — Cast High Noble Metal — Three or More Surfaces	$ 175
D6604	Inlay — Cast Predominantly Base Metal — Two Surfaces	$ 100
D6605	Inlay — Cast Predominantly Base Metal — Three or More Surfaces	$ 100
D6606	Inlay — Cast Noble Metal — Two Surfaces	$ 155
D6607	Inlay — Cast Noble Metal — Three or More Surfaces	$ 155
D6610	Onlay — Cast High Noble Metal — Two Surfaces	$ 185
D6611	Onlay — Cast High Noble Metal — Three or More Surfaces	$ 185
D6612	Onlay — Cast Predominantly Base Metal — Two Surfaces	$ 100
D6613	Onlay — Cast Predominantly Base Metal — Three or More Surfaces	$ 100
D6614	Onlay — Cast Noble Metal — Two Surfaces	$ 175
D6615	Onlay — Cast Noble Metal — Three or More Surfaces	$ 175
D6624	Inlay — Titanium	$ 175
D6634	Onlay — Titanium	$ 185

Fixed Partial Denture Retainers — Crown

D6720	Crown — Resin with High Noble Metal	$ 150
D6721	Crown — Resin with Predominantly Base Metal	$ 150
D6722	Crown — Resin with Noble Metal	$ 150
D6740	Crown — Porcelain/Ceramic	$ 200
D6750	Crown — Porcelain Fused to High Noble Metal	$ 225
D6751	Crown — Porcelain Fused to Predominantly Base Metal	$ 200
D6752	Crown — Porcelain Fused to Noble Metal	$ 200
D6780	Crown — 3/4 Cast High Noble Metal	$ 225
D6781	Crown — 3/4 Cast Predominantly Base Metal	$ 200
D6782	Crown — 3/4 Cast Noble Metal	$ 200
D6783	Crown — 3/4 Porcelain/Ceramic	$ 200

D6790	Crown — Full Cast High Noble Metal	$ 225
D6791	Crown — Full Cast Predominantly Base Metal	$ 200
D6792	Crown — Full Cast Noble Metal	$ 200
D6794	Crown — Titanium	$ 225

Other Fixed Partial Denture Services

D6930	Recement Fixed Partial Denture	$ 15
D6970	Cast Post and Core in Addition to Bridge Retainer	$ 40
D6971	Cast Post as Part of Fixed Partial Denture	$ 40
D6972	Prefabricated Post and Core in Addition to Bridge Retainer	$ 40
D6973	Core Buildup for Retainer Including Pins	$ 0
D6980	Fixed Partial Denture Repair — By Report	$ 25

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

Extractions *(Includes Local Anesthesia, Suturing, if Needed, and Routine Post-Operative Care)*

D7111	Extraction — Coronal Remnants — Deciduous Tooth	$ 10
D7140	Extraction — Erupted Tooth or Exposed Root *(Elevation and/or Forceps Removal)*	$ 20

Surgical Extractions *(Includes Local Anesthesia, Suturing, if Needed, and Routine Post-Operative Care)*

D7210	Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth	$ 30
D7220	Removal of Impacted Tooth — Soft Tissue	$ 55
D7230	Removal of Impacted Tooth — Partially Bony	$ 55
D7240	Removal of Impacted Tooth — Completely Bony	$ 65
D7241	Removal of Impacted Tooth — Completely Bony with Complications	$ 65
D7250	Surgical Removal of Residual Tooth Roots — Cutting Procedure	$ 30

Other Surgical Procedures

D7260	Oroantral Fistula Closure	$ 100
D7270	Tooth Reimplantation/Stabilization	$ 60
D7280	Surgical Access of an Unerupted Tooth	$ 60
D7282	Mobilization of Erupted or Malpositioned Tooth to Aid Eruption	$ 60
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth	$ 0
D7285	Biopsy of Oral Tissue — Hard *(Bone, Tooth)*	$ 60
D7286	Biopsy of Oral Tissue — Soft	$ 25
D7291	Transseptal Fiberotomy Supra Crestal Fiberotomy — By Report	$ 20

Alveoloplasty-Surgical Preparation of the Ridge for Dentures

D7310	Alveoloplasty in Conjunction with Extraction — Per Quadrant	$ 30
D7311	Alveoloplasty in Conjunction with Extractions — One to Three Teeth or Tooth Spaces per Quadrant	$ 15

D7320	Alveoloplasty Not in Conjunction with Extractions — Per Quadrant	$ 35
D7321	Alveoloplasty Not in Conjunction with Extractions — One to Three Teeth or Tooth Spaces per Quadrant	$ 20

Removal of Cysts, Tumors, and Neoplasms

D7450	Removal of Benign Odontogenic Cyst or Tumor — Lesion Up to 1.25 cm Diameter	$ 60
D7451	Removal of Benign Odontogenic Cyst or Tumor — Lesion Greater than 1.25 cm Diameter	$ 60
D7460	Removal of Benign Non-Odontogenic Cyst or Tumor — Leision Up to 1.25 cm Diameter	$ 60
D7461	Removal of Benign Non-Odontogenic Cyst or Tumor — Leision Greater than 1.25 cm Diameter	$ 60

Excision of Bone Tissue

D7471	Removal of Lateral Exostosis — Maxilla or Mandible	$ 90
D7472	Removal Torus Palatinus	$ 90
D7473	Removal Torus Mandibularis	$ 90
D7485	Surgical Reduction of Osseous Tuberosity	$ 90

Surgical Incision

D7510	Incision and Drainage of Abscess — Intraoral — Soft Tissue	$ 25
D7511	Incision and Drainage of Abscess — Intraoral — Soft Tissue — Complicated *(Includes Drainage of Multiple Facial Spaces)*	$ 30
D7520	Incision and Drainage of Abscess — Extraoral — Soft Tissue	$ 35
D7521	Incision and Drainage of Abscess — Extraoral — Soft Tissue — Complicated *(Includes Drainage of Multiple Facial Spaces)*	$ 40

Other Repair Procedures

D7953	Bone Replacement Graft for Ridge Preservation — Per Site	$ 75
D7960	Frenulectomy — Separate Procedure	$ 60
D7963	Frenuloplasty	$ 65
D7970	Excision of Hyperplastic Tissue — Per Arch	$ 60
D7971	Excision of Pericoronal Gingiva	$ 30
D7972	Surgical Reduction of Fibrous Tuberosity	$ 60

Miscellaneous Services

D9110	Palliative *(Emergency)* Treatment of Dental Pain — Minor Procedure	$ 0
D9211	Regional Block Anesthesia	$ 0
D9212	Trigeminal Division Block Anesthesia	$ 0
D9215	Local Anesthesia	$ 0
D9220	Deep Sedation/General Anesthesia — First 30 Minutes	$ 40
D9221	Deep Sedation/General Anesthesia — Each Additional 15 Minutes	$ 20
D9230	Analgesia, Anxiolysis, Inhalation of Nitrous Oxide	$ 0
D9241	Intravenous Conscious Sedation/Analgesia — First 30 Minutes	$ 40

D9242	Intravenous Conscious Sedation/Analgesia — Each Additional 15 Minutes	$ 20
D9310	Consultation *(Diagnostic Service Provided by a Dentist or Physician other than Practitioner Providing Treatment)*	$ 0
D9430	Office Visit Observation	$ 0
D9440	Office Visit After Hours	$ 0
D9610	Therapeutic Drug Injection — By Report	$ 0
D9630	Other Drugs and/or Medications — By Report	$ 0
D9910	Application of Desensitizing Medication	$ 0
D9930	Treat Complications — By Report	$ 0
D9940	Occlusal Guard — By Report	$ 40
D9942	Repair and/or Reline of Occlusal Guard	$ 20
D9951	Occlusal Adjustment — Limited	$ 0
D9952	Occlusal Adjustment — Complete	$ 60

Orthodontics

(*Treatment plan maximum of 24 months*)

1. Patient under 18 years of age at the start of treatment — Class I, II, and III malocclusion (copayment required of $1,000 or 50 percent of reasonable and customary charges, whichever is less).
2. Patient 18 years of age or over at the start of treatment — Class I, II, and III malocclusion (copayment required of $1,750 or 50 percent of reasonable and customary charges, whichever is less). Includes Invisalign as an optional treatment procedure — this procedure may fall under the "More Expensive Services" option and as such, the member choosing this option would be responsible for the difference between Invisalign charges and the standard adult orthodontic charge.

More Expensive Services

A covered individual may elect a more expensive procedure than an appropriate procedure recommended by the dentist. The covered individual shall pay any copayment required for the less expensive procedure plus the difference in cost between the two procedures on the basis of the reasonable and customary dental charges for the procedures.

Emergency Services — Out-of-Area

Emergency Treatment is defined as, "when a covered SHBP member or dependent is at least 50 miles from home, any necessary service or procedure which is rendered as the direct result of an 'unforeseen' occurrence and requires immediate, urgent action or remedy". Examples are, acute pain, bleeding, fractured tooth, broken filling, broken front tooth, broken denture, and lost or loose crown. The reimbursement shall be at the full amount of the charge up to a maximum of $100 per episode.

SERVICES THAT ARE NOT COVERED BY THE DPO

- A service started before the person became a covered individual under the plan.
- Replacement of lost, stolen, or damaged prosthodontic devices within two years of the date of initial installation.
- A service not reasonably necessary for the dental care of a covered individual or provided solely for cosmetic purposes.
- Providing supplies of a type normally intended for home use, such as toothpaste, toothbrushes, waterpicks, and mouthwash.
- A service required because of war or an act of war.
- A service made available to a covered individual or financed by the federal, state, or local government. This includes the federal Medicare program and any similar federal program, any Workers' Compensation law or similar law, any automobile no-fault law, or any other program or law under which the covered individual is, or could be, covered. The exclusion is applicable whether or not the covered individual receives the service, makes a claim or receives compensation for the service, or receives a recovery from a third party for damages.
- A service not furnished by a dentist or physician licensed to provide the dental service, except for a service performed by a licensed dental hygienist under the direction of a dentist.
- General anesthesia, except when medically necessary in connection with covered oral and periodontal surgery procedures.
- Hospitalization.
- Any dental implant including any crowns, prostheses, devices, or appliances attached to implants.
- Experimental procedures.
- Appliances, restorations, and procedures to alter vertical dimension and/or restore occlusion, including temporomandibular joint dysfunction, except oral splints.
- Procedures that are not listed.
- A service covered under any medical, surgical, or major medical plan (including a Health Maintenance Organization — HMO) provided by the employer.

APPENDIX I

CLAIM APPEAL PROCEDURES

You or your authorized representative may appeal and request that your dental plan reconsider any claim or any portion(s) of a claim for which you believe benefits have been erroneously denied based on the plan's limitations and/or exclusions. This appeal may be of an administrative or medical/dental nature. Administrative appeals might question eligibility or plan benefit decisions such as whether a particular service is covered or paid appropriately. Medical appeals refer to the determination of medical/dental need, appropriateness of treatment, or experimental and/or investigational procedures.

The following information must be given at the time of each inquiry.

- Name(s) and address(es) of patient and employee;
- Employee's identification number;
- Date(s) of service(s);
- Provider's name and identification number;
- The specific remedy being sought; and
- The reason you think the claim should be reconsidered.

If you have any additional information or evidence about the claim that was not given when the claim was first submitted, be sure to include it.

Any member of the Dental Expense Plan who disagrees with a final decision of Aetna may request, in writing, that the matter be considered by the State Health Benefits Commission. Requests for consideration must be directed to the *Appeals Coordinator, State Health Benefits Commission, PO Box 299, Trenton, NJ 08625-0299* and must contain the reason for the disagreement and a copy of all relevant correspondence. Appeals are considered at regular monthly meetings of the Commission. It is the responsibility of the member to provide the Commission with any medical or other information that the Commission may require in order to make a decision.

Any member of a Dental Plan Organization (DPO) who disagrees with a determination of the appropriateness of a procedure made by a DPO or any member of a DPO who feels that the DPO has violated the terms and conditions of its contract with the SHBP may request, in writing, that the matter be considered by the State Health Benefits Commission. Such an appeal can only be considered after the member has exhausted the DPO's grievance process.

Upon request, your DPO will supply you with its grievance procedures. Requests for consideration must be directed to the *Appeals Coordinator, State Health Benefits Commission, PO Box 299, Trenton, NJ 08625-0299* and must contain the reason for the disagreement and a copy of all relevant correspondence and supporting documentation. Appeals are considered at regular monthly meetings of the Commission.

Notification of all Commission decisions will be made in writing to the member. If the Commission denies the member's appeal, the member will be informed of further steps (s)he may take in the denial letter from the Commission. Any member who disagrees with the Commission's decision may request within 45 days in writing to the Commission that the case be forwarded to the Office of Administrative Law. The Commission will then determine if a factual hearing is necessary. If so, the case will be forwarded to the Office of Administrative Law. An Administrative Law judge will hear the case and make a recommendation to the Commission, which the Commission may adopt, modify, or reject. If a factual hearing is not necessary, the administrative appeal process involving the Commission is ended. When the administrative process is completed, further appeals may be made to the Superior Court of New Jersey, Appellate Division.

If your case is forwarded to the Office of Administrative Law, you will be responsible for the presentation of your case and for submitting all evidence. You will be responsible for any expenses involved in gathering evidence or material that will support your grounds for appeal. If you take your appeal to Superior Court, you will be responsible for any court filing fees or similar related costs that may be necessary during the appeal's process. If you require an attorney or expert medical testimony, you will be responsible for any fees or costs incurred.

APPENDIX II

GLOSSARY

Alveolectomy — Surgical excision of a portion of the dentoalveolar process, for re-contouring the tooth socket ridge at the time of tooth removal in preparation for a dental prosthesis (denture).

Amalgam — An alloy used in dental restoration.

Apicoectomy — Surgical removal of a dental root apex. Root resection.

Appeal — A request made by a member, doctor, or facility that a carrier review a decision concerning a claim. Administrative appeals question plan benefit decisions such as whether a particular service is covered or paid appropriately. Medical appeals refer to the determination of need or appropriateness of treatment or whether treatment is considered experimental or educational in nature. Appeals to the State Health Benefits Commission may only be filed by a member or the member's legal representative.

Bitewing X-Ray — X-rays taken with the film holder held between the teeth and the film parallel to the teeth.

Calendar Year — A year starting January 1 and ending on December 31.

COBRA — Consolidated Omnibus Budget Reconciliation Act of 1985. This federal law requires private employers with more than 20 employees and all public employers to allow covered employees and their dependents to remain on group insurance plans for limited time periods at their own expense under certain conditions.

Coinsurance — The portion of an eligible charge which is the member's financial responsibility.

Coordination of Benefits — The practice of correlating the payments a plan makes with payments provided by other insurance covering the same charges or expenses, so that (1) the plan with primary responsibility pays first, (2) reimbursement by the two plans does not exceed 100 percent of the allowable expense, and (3) the dental plan does not pay more than it would if no other insurance existed.

Copayment — The portion of an eligible charge under a DPO which is the member's financial responsibility.

Crossbite — An abnormal relation of one or more teeth of one arch to the opposing tooth or teeth of the other arch.

Crown — That part of a tooth that is covered with enamel or an artificial substitute for that part.

Deductible — The first eligible expense, or portion thereof, incurred within each calendar year that the member is required to pay before reimbursement for eligible expenses begins.

Dependent Coverage — Coverage of an eligible family member of an enrolled member.

Domestic Partner — Domestic Partner is defined for SHBP eligibility under Chapter 246, P.L. 2003 as a person of the same sex with whom the employee has entered into a domestic partnership and filed an Affidavit of Domestic Partnership with the local registrar. Local participating employers must have adopted a resolution to provide the SHBP Domestic Partnership benefit for this coverage to apply to local employees (see Fact Sheet #71, *Benefits Under the Domestic Partnership Act,* for more information).

Eligible Dependent — A member's spouse or same-sex domestic partner (as defined by Chapter 246, P.L. 2003) and unmarried child(ren) under the age of 23 who lives with and is substantially dependent upon the member for support. Children include natural, adopted, foster, and stepchildren. If a covered child is not capable of self-support when (s)he reaches age 23 due to mental illness, mental retardation, or a physical disability, coverage under the SHBP may be continued (see page 3).

Employer — The State, or a local public employer which participates in the State Health Benefits Program.

Endodontics — Concerned with the biology and pathology of the dental pulp and surrounding tissues. Root canal treatment.

Gingivectomy — Removal of gum tissue.

Gingivoplasty — A surgical procedure that reshapes and recontours the gum tissue in order to attain functional form.

Inlay — A cast metallic or ceramic filling for a dental cavity.

Local Employee — For purposes of SHBP coverage, a local employee is a full-time employee receiving a salary and working for a Participating Local Employer. Full-time shall mean employment of an eligible employee who appears on a regular payroll and who receives salary or wages for an average number of hours specified by the employer, but not to be less than 20 hours per week. It also means employment in all 12 months of the year except in the case of those employees engaged in activities where the normal work schedule is 10 months. In addition, for local coverage, employee shall also mean an appointed or elected officer of the local employer, including an employee who is compensated on a fee basis as a convenient method of payment of wages or salary but who is not a self-employed independent contractor compensated in a like manner. To qualify for coverage as an appointed officer, a person must be appointed to an office specifically established by law, ordinance, resolution, or such other official action required by law for establishment of a public office by an appointing authority. A person appointed under a general authorization, such as to appoint officers or to appoint such other officers or similar language is not eligible to participate in the program as an appointed officer. An officer appointed under a general authorization must qualify for participation as a full-time employee.

Local Employer — Government employers in New Jersey, including counties, municipalities, townships, school districts, community colleges, and various public agencies or organizations.

Mandibular — Relating to the lower jaw.

Maxillary — Relating to the upper jaw.

Member — With respect to the Employee Dental Plans, employees eligible to enroll in the State Health Benefits Program and their dependents including a spouse or eligible same-sex domestic partner.

Myofunctional — Relating to the role of muscle function in the correction of oral problems.

Onlay — A type of metal or ceramic restoration that overlays the tooth to provide additional strength to that tooth.

Orthodontic — Concerned with the correction and prevention of irregularities of the teeth. Dental orthopedics.

Osteoplasty — Resection of the bony structure to achieve acceptable gum contour.

Palliative Treatment — Alleviation of symptoms without curing the underlying disease.

Periodontics — Concerned with the treatment of abnormal conditions and diseases of the tissues that surround and support the teeth.

Pontic — An artificial tooth on a fixed partial denture.

Prophylaxis — A series of procedures whereby calculus (calcified deposits), stain, and other accretions are removed from the clinical crowns of the teeth and the enameled surfaces are polished.

Prosthodontics — The science of and art of providing suitable substitutes for crowns of teeth, or for replacing lost or missing teeth.

Pulpotomy — Removal of a portion of the pulp structure of a tooth, usually the coronal portion.

Reasonable and Customary — A charge by a dentist, or by any other provider of services or supplies, that does not exceed the prevailing charge for the same service or supply made by similar providers in the same geographic area. The member is responsible for any amount a dentist or provider charges above the reasonable and customary allowance.

Resin — A material used in dental restoration.

Scaling and Root Planing — The removal of subgingival calcified deposits around the teeth and the cleaning of the gingival pocket.

State Health Benefits Commission (Commission) — The entity created by N.J.S.A. 52:14-17.27 and charged with the responsibility of establishing and overseeing the State Health Benefits Program.

State Health Benefits Program (SHBP) — The SHBP was originally established by statute in 1961. It offers medical, prescription drug, and dental coverage to qualified public employees and retirees, and their eligible dependents. Local employers must adopt a resolution to participate in the SHBP and its plans. The State Health Benefits Program Act is found in the N.J.S.A. 52:17.25 et.seq. Rules governing the operation

and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

State Monthly Employee — For purposes of SHBP coverage, state monthly employee shall mean a full-time employee of the State, or an appointed or elected officer, whose benefits are based on a monthly cycle and whose payroll system is autonomous (not paid by the State's centralized payroll system). Full-time shall mean the usual full-time weekly schedule for the particular title, which normally requires 35 hours per week.

State Monthly Employer — Employers whose benefits are based on a monthly cycle and whose payroll system is autonomous (not paid by the State's centralized payroll system). This includes state colleges and universities and participating independent state commissions, authorities, and agencies such as:

- Rutgers, the State University of New Jersey
- Palisades Interstate Park Commission
- New Jersey Institute of Technology
- University of Medicine and Dentistry of NJ
- Thomas A. Edison State College
- William Paterson University
- Ramapo State College
- Rowan University
- College of New Jersey
- Montclair State University
- New Jersey City University
- Kean University
- Stockton State College
- New Jersey State Library
- New Jersey State Legislature and legislative offices
- New Jersey Building Authority
- New Jersey Commerce and Economic Growth Commission
- Waterfront Commission of New York Harbor
- Agencies or special projects that are supported from, or whose employees are paid from, sources of revenue other than general funds, which other funds shall bear the cost of benefits under this program.

Temporo-mandibular — Denoting the joint of the lower jaw.

APPENDIX III

AVAILABLE DENTAL PLANS

UNIT/ DPO #	NAME	MEMBERSHIP SERVICES PHONE #	2005 PLAN YEAR SERVICE AREA*
301	Atlantic Southern Dental Foundation (BeneCare)	1-800-843-4727	All of New Jersey (Except Hunterdon, Morris, Passaic, Salem, Somerset, Sussex & Warren Counties)
302	Community Dental Associates	(856) 451-8844	Cumberland County
305	CIGNA Dental Health, Inc	1-800-367-1037	All of New Jersey (Except Cape May County); Eastern Pennsylvania
307	Healthplex (International Health Care Services)	1-800-468-0600	All of New Jersey (Except Cape May, Glouster, Hunterdon, Salem, Sussex & Warren Counties); Bucks County and Philadelphia, Pennsylvania
317	Horizon Dental Choice	1-800-433-6825	All of New Jersey (Except Salem County)
319	Aetna DMO	1-800-843-3661	All of New Jersey, Eastern Pennsylvania
399	Dental Expense Plan (Administered by Aetna)	1-877-238-6200	Unrestricted

*If a county is listed as not served, there are an insufficient number of dental providers within the county for the respective DPO network. For specific areas of service, contact the DPO or see your benefits administrator for a list of dental providers for each DPO.

APPENDIX IV

TAX$AVE FOR STATE EMPLOYEES

Tax$ave is a benefit program defined by Section 125 of the federal Internal Revenue Code that allows eligible New Jersey State employees to use pre-tax dollars to pay for qualified medical, dental, and dependent care expenses and thereby increase their take-home pay. The pre-tax deduction effectively reduces the salary on which taxes are computed by the amount of the health, dental, or dependent care deduction.

Tax$ave consists of three components:

- The **Premium Option Plan** (POP) allows eligible New Jersey State employees to make payments for basic health and dental plan premiums on a pre-tax basis and thereby increase their take-home pay. Any increase in take-home pay will depend on the health and/ or dental plan selected and the level of coverage (single, member and spouse, parent and child(ren) or family).
- The **Unreimbursed Medical Spending Account Plan** (UMSA) allows eligible New Jersey State employees to set aside money to pay for qualified medical and dental expenses not paid by any group benefits plan under which they or their dependents are covered (see limitations on same-sex domestic partners, on page 41).
- The **Dependent Care Spending Account Plan** (DCSA) allows an eligible New Jersey State employee to set aside funds to pay for anticipated expenses related to dependent care required to permit the employee and spouse to work.

  (The UMSA and DCSA are administered for the Division of Pensions and Benefits by the Horizon Healthcare Insurance Agency.)

Fact Sheet #44, *Tax$ave,* outlines the Tax$ave Program and may be obtained from your benefits administrator or from the Division of Pensions and Benefits by calling the Benefit Information Library at (609) 777-1931. After the introduction, enter information selection number 266 when prompted. You will hear a recorded message about the Tax$ave Program, after which you can request the fact sheet to be sent by mail or fax.

You can also visit the Division's' Tax$ave Internet page at:
www.state.nj.us/treasury/pensions/taxsave.htm

Note: The *Tax$ave* program is not available to local employees. Contact your employer to find out if you are eligible to pay premiums on a pre-tax basis through an IRC Section 125 Program offered by your employer.

Tax$ave Open Enrollment

You may join a Tax$ave or make changes to your Tax$ave accounts during the Tax$ave Open Enrollment period. Enrollment in the POP is automatic unless you decline enrollment each year. You can enroll in the UMSA or DCSA by calling the Horizon Healthcare Insurance Agency at 1-800-224-4426.

EFFECT OF POP PARTICIPATION ON SHBP RULES AND PROCEDURES

Your participation in the **Premium Option Plan** (POP) may effect your participation in the State Health Benefits Program.

As a State employee you are automatically enrolled in the POP and save on taxes for any health and/or dental premiums you pay through payroll deductions — unless you decline enrollment at the time you first become eligible for health and dental plan coverage or during the Tax$ave Open Enrollment period (see "Declining POP" below).

The Tax$ave Program is strictly regulated by the Internal Revenue Service (IRS) because of the tax advantages provided under the POP. IRS rules require that for an employee covered by the POP, payroll deductions for health and/or dental plan benefits remain the same for the entire plan year. Therefore, no coverage level changes can be made to your health and/or dental plan enrollment that would result in a change in the amount of your deduction unless a "Qualifying Event" has occurred. If a Qualifying Event does occur (see below), you may make a change by submitting a completed application to your employer within 60 days of a Qualifying Event or during the annual Tax$ave Open Enrollment period.

Qualifying Events:

- A marriage (employee may enroll spouse and any other eligible dependents).
- Addition of an eligible dependent due to birth, adoption, or legal guardianship.
- A change in family status involving the loss of eligibility of a family member (separation, divorce, death, child marries, no longer lives at home, or turns age 23).
- A move outside an HMO service area.
- The termination of a member's employment for any reason, including retirement.
- The taking of an approved unpaid leave of absence.
- A change in a spouse's or eligible dependent's employment status resulting in their loss of health and/or dental coverage.
- A child, under the age of 23, has divorced and moves back into the employee's household and is dependent upon the employee for support and maintenance.
- Such other events that may be determined to be appropriate and in accordance with applicable IRS regulations.

Declining POP

Since enrollment is automatic for employees with health or dental plan deductions, a newly hired employee who does not want to participate in the POP may decline participation by completing a *Declination of Premium Option Plan* form that can be obtained from the employee's Human Resources Representative or Payroll Clerk.

Leave Without Pay (LWOP)

The election in effect at the beginning of the plan year will continue until a change is made during the Tax$ave Open Enrollment period or upon the occurrence of a Qualifying Event. An employee who declined enrollment in the POP and is on leave during the Annual Open Enrollment Period may elect enrollment in the POP upon return to active employment.

DOMESTIC PARTNERS AND TAX$AVE

The Internal Revenue Service does not recognize a New Jersey same-sex domestic partner as a dependent for tax purposes in the same manner that it recognizes a spouse or dependent children of an employee. Therefore, your employer may have to treat the same-sex domestic partner SHBP benefit as federally taxable.

As a result, a same-sex domestic partner must be able to qualify as a "tax dependent" of the employee for federal tax filing purposes — under Internal Revenue Code Section 152 — before an out-of-pocket medical or dental expense incurred by the same-sex domestic partner can be reimbursed under the Unreimbursed Medical Spending Account and before any premiums that the employee pays for the same-sex domestic partner coverage can be made on a pre-tax basis under the Premium Option Plan. See *IRS Tax Topic 354 - Dependents* for additional information on the requirements for establishing dependent status for federal tax purposes.

If the same-sex domestic partner is not a "qualified tax dependent" of the employee, the domestic partner's SHBP coverage is considered federally taxable and the employee cannot be reimbursed under the Unreimbursed Medical Spending Account for any out-of-pocket medical or dental expense incurred by the domestic partner, nor make pre-tax payments for the cost of the domestic partner's coverage under the Premium Option Plan. (Pre-tax dollars may still be used to pay for the employee's portion of the cost of his or her own and dependent children's coverage.)

The same-sex domestic partner SHBP benefit is not subject to New Jersey State income tax. If you live outside of New Jersey, you should check with your State's tax agency to determine if the same-sex domestic partner SHBP benefit is subject to state taxes.

Additional information about the New Jersey Domestic Partnership Act can be found in Fact Sheet #71, *Benefits Under the Domestic Partnership Act.* See page 48 for information on how to obtain this publication.

APPENDIX V

NOTICE OF PRIVACY PRACTICES TO ENROLLEES IN THE NEW JERSEY STATE HEALTH BENEFITS PROGRAM

This Notice describes how medical (and dental) information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

EFFECTIVE DATE: APRIL 14, 2003.

Protected Health Information

The State Health Benefits Program (SHBP) is required by the federal Health Insurance Portability and Accountability Act (HIPAA) and State laws to maintain the privacy of any information that is created or maintained by the SHBP that relates to your past, present, or future physical or mental health. This Protected Health Information (PHI) includes information communicated or maintained in any form. Examples of PHI are your name, address, Social Security number, birth date, telephone number, fax number, dates of health care service, diagnosis codes, and procedure codes. PHI is collected by the SHBP through various sources, such as enrollment forms, employers, health care providers, federal and State agencies, or third-party vendors.

The SHBP is required by law to abide by the terms of this Notice. The SHBP reserves the right to change the terms of this Notice. If the SHBP makes material change to this Notice, a revised Notice will be sent.

SHBP Uses and Disclosures of PHI

The SHBP is permitted to use and to disclose PHI in order for our members to obtain payment for health care services and to conduct the administrative activities needed to run the SHBP without specific member authorization. Under limited circumstances, we may be able to provide PHI for the health care operations of providers and health plans. Specific examples of the ways in which PHI may be used and disclosed are provided below. This list is illustrative only and not every use and disclosure in a category is listed.

- The SHBP may disclose PHI to a doctor or a hospital to assist them in providing a member with treatment.
- The SHBP may use and disclose member PHI so that our Business Associates may pay claims from doctors, hospitals, and other providers.
- The SHBP receives PHI from employers, including the member's name, address, Social Security number, and birth date. This enrollment information is provided to our Business Associates so that they may provide coverage for health care benefits to eligible members.

- The SHBP and/or our Business Associates may use and disclose PHI to investigate a complaint or process an appeal by a member.
- The SHBP may provide PHI to a provider, a health care facility, or a health plan that is not our Business Associate that contacts us with questions regarding the member's health care coverage.
- The SHBP may use PHI to bill the member for the appropriate premiums and reconcile billings we receive from our Business Associates.
- The SHBP may use and disclose PHI for fraud and abuse detection.
- The SHBP may allow use of PHI by our Business Associates to identify and contact our members for activities relating to improving health or reducing health care costs, such as information about disease management programs or about health-related benefits and services or about treatment alternatives that may be of interest to them.
- In the event that a member is involved in a lawsuit or other judicial proceeding, the SHBP may use and disclose PHI in response to a court or administrative order as provided by law.
- The SHBP may use or disclose PHI to help evaluate the performance of our health plans. Any such disclosure would include restrictions for any other use of the information other than for the intended purpose.
- The SHBP may use PHI in order to conduct an analysis of our claims data. This information may be shared with internal departments such as auditing or it may be shared with our Business Associates, such as our actuaries.

Except as described above, unless a member specifically authorizes us to do so, the SHBP will provide access to PHI only to the member, the member's authorized representative, and those organizations who need the information to aid the SHBP in the conduct of its business (our "Business Associates"). An authorization form may be obtained over the Internet at: *www.state.nj.us/treasury/pensions* or by sending an e-mail to: *hipaaform@treas.state.nj.us*. A member may revoke an authorization at any time.

When using or disclosing PHI, the SHBP will make every reasonable effort to limit the use or disclosure of that information to the minimum extent necessary to accomplish the intended purpose. The SHBP maintains physical, technical and procedural safeguards that comply with federal law regarding PHI.

Member Rights

Members of the SHBP have the following rights regarding their PHI:

Right to Inspect and Copy: With limited exceptions, members have the right to inspect and/or obtain a copy of their PHI that the SHBP maintains in a designated record set which consists of all documentation relating to member enrollment and the SHBP's use of this PHI for claims resolution. The member must make a request in writing to obtain access to their PHI. The member may use the contact information found at the end of this Notice to obtain a form to request access.

Right to Amend: Members have the right to request that the SHBP amend the PHI that we have created and that is maintained in our designated record set.

We cannot amend demographic information, treatment records or any other information created by others. If members would like to amend any of their demographic information, please contact your personnel office. To amend treatment records, a member must contact the treating physician, facility, or other provider that created and/or maintains these records.

The SHBP may deny the member's request if: 1) we did not create the information requested on the amendment; 2) the information is not part of the designated record set maintained by the SHBP; 3) the member does not have access rights to the information; or 4) we believe the information is accurate and complete. If we deny the member's request, we will provide a written explanation for the denial and the member's rights regarding the denial.

Right to an Accounting of Disclosures*:* Members have the right to receive an accounting of the instances in which the SHBP or our Business Associates have disclosed member PHI. The accounting will review disclosures made over the past six years or back to April 14, 2003, whichever period is shorter. We will provide the member with the date on which we made a disclosure, the name of the person or entity to whom we disclosed the PHI, a description of the information we disclosed, the reason for the disclosure, and certain other information. Certain disclosures are exempted from this requirement (e.g., those made for treatment, payment or health benefits operation purposes or made in accordance with an authorization) and will not appear on the accounting.

Right to Request Restrictions: The member has the right to request that the SHBP place restrictions on the use or disclosure of their PHI for treatment, payment, or health care operations purposes. The SHBP is not required to agree to any restrictions and in some cases will be prohibited from agreeing to them. However, if we do agree to a restriction, our agreement will always be in writing and signed by the Privacy Officer. The member request for restrictions must be in writing. A form can be obtained by using the contact information found at the end of this Notice.

Right to Request Confidential Communications: The member has the right to request that the SHBP communicate with them in confidence about their PHI by using alternative means or an alternative location if the disclosure of all or part of that information to another person could endanger them. We will accommodate such a request if it is reasonable, if the request specifies the alternative means or locations, and if it continues to permit the SHBP to collect premiums and pay claims under the health plan.

To request changes to confidential communications, the member must make their request in writing, and must clearly state that the information could endanger them if it is not communicated in confidence as they requested.

Questions and Complaints

If you have questions or concerns, please contact the SHBP using the information listed at the end of this Notice. (Local county, municipal, and Board of Education employees should contact the HIPPA Privacy Officer for their employer.)

If members think the SHBP may have violated their privacy rights, or they disagree with a decision made about access to their PHI, in response to a request made to amend or restrict the

use or disclosure of their information, or to have the SHBP communicate with them in confidence by alternative means or at an alternative location, they must submit their complaint in writing. To obtain a form for submitting a complaint, use the contact information found at the end of this Notice.

Members also may submit a written complaint to the U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201.

The SHBP supports member rights to protect the privacy of PHI. It is your right to file a complaint with the SHBP or with the U.S. Department of Health and Human Services.

Contact Office:	The State Health Benefits Program—HIPAA Privacy Officer
Address:	State of New Jersey Department of the Treasury Division of Pensions and Benefits Bureau of Policy and Planning PO Box 295 Trenton, NJ 08625-0295
Fax:	(609) 341-3410
E-mail:	*hipaaform@treas.state.nj.us*

STATE HEALTH BENEFITS PROGRAM CONTACT INFORMATION

ADDRESSES

Our Mailing Address is . . . . . The State Health Benefits Program
Division of Pensions and Benefits
PO Box 299
Trenton, NJ 08625-0299

Our Internet Address is . . . . . *www.state.nj.us/treasury/pensions/shbp.htm*

Our E-mail Address is . . . . . *.pensions.nj@treas.state.nj.us*

TELEPHONE NUMBERS

Division of Pensions and Benefits:

Benefit Information Library/Fax on Demand	(609) 777-1931
Office of Client Services	(609) 292-7524
TDD Phone (Hearing Impaired)	(609) 292-7718

Dental Expense Plan — Aetna Dental	1-877-238-6200

Dental Plan Organizations

Aetna DMO	1-800-843-3661
Atlantic Southern Dental Foundation (BeneCare)	1-800-843-4727
CIGNA Dental Health, Inc	1-800-367-1037
Community Dental Associates	(856) 451-8844
Healthplex (International Health Care Services)	1-800-468-0600
Horizon Dental Choice	1-800-433-6825

RELATED HEALTH SERVICES

State Employee Advisory Service (EAS)	(609) 292-8543
Rutgers University Personnel Counseling Service (EAP)	(732) 932-7539
New Jersey State Police Employee Advisory Program (EAP)	(856) 234-5652
	(908) 231-1077
	(609) 633-3718
	1-800-FOR-NJSP
University of Medicine and Dentistry of New Jersey (EAP)	(973) 972-5429
New Jersey Department of Banking and Insurance	
Individual Health Coverage Program Board	1-800-838-0935
Consumer Assistance for Health Insurance	(609) 292-5316 (Press 2)
New Jersey Department of Human Services	
Pharmaceutical Assistance to the Aged and Disabled (PAAD)	1-800-792-9745
New Jersey Department of Health and Senior Services	
Division on Senior Affairs	1-800-792-8820
Insurance Counseling	1-800-792-8820
Independent Health Care Appeals Program	(609) 633-0660
Centers for Medicare and Medicaid Services	1-800-Medicare
New Jersey Medicare - Part A	1-866-641-2007
New Jersey Medicare - Part B	1-800-462-9306

STATE HEALTH BENEFITS PROGRAM PUBLICATIONS

The publications and fact sheets available from the Division of Pensions and Benefits provide information on a variety of subjects. Employees and retirees can obtain copies of these publications by contacting their employers or by calling the Division. Our Benefit Information Library (BIL) is available 24 hours-a-day, seven days-a-week. If the items you require have a BIL number, dial (609) 777-1931, from a touch-tone phone, and enter the three-digit BIL selection number when instructed. After the recorded information leave your name, mailing address with ZIP Code, and Social Security number to have the publication or fact sheet mailed to you.

If the items you require have a Fax on Demand (FOD) number, you can have the publication or fact sheet automatically faxed to your fax machine. To use our Fax on Demand service, dial (609) 777-1931. Follow the instructions to access Fax on Demand and, when requested, enter the four-digit FOD selection number along with your fax number (area code and telephone).

Fact sheets and other publications are also available for viewing or downloading over the Internet at: *www.state.nj.us/treasury/pensions*

General Publications

State Health Benefits Program Summary Program Description booklet

State Health Benefits Program Comparison Summary - Plan comparison chart. (State Employees - FOD #8251; Local Employees - BIL #250, FOD #8130; All Retirees - BIL #130, FOD #8130)

Benefit Information Library Catalog - A catalog of informational items available through the Benefit Information Library and Fax on Demand service. (FOD #8000)

SHBP Fact Sheets

Fact Sheet #11, *Enrolling in the State Health Benefits Program When you Retire.* (BIL #208) (FOD #8208)

Fact Sheet #23, *The State Health Benefits Program and Medicare Parts A and B for Retirees.* (BIL #134) (FOD #8134)

Fact Sheet #25, *Employer Responsibilities under COBRA.* (BIL #345) (FOD #8345)

Fact Sheet #26, *Health Benefits Options upon Termination of Employment.* (BIL #258) (FOD #8258)

Fact Sheet #30, *The Continuation of New Jersey State Health Benefits Program Coverage Under COBRA.* (BIL #254) (FOD #8254)

Fact Sheet #37, *SHBP Employee Dental Plans.* (BIL #256) (FOD #8256)

Fact Sheet #47, *SHBP Retired Coverage Under Chapter 330 - PFRS and LEO.* (BIL #136) (FOD #8136)

Fact Sheet #51, *Continuing SHBP Coverage for Overage Children with Disabilities.* (BIL #259) (FOD #8259)

Fact Sheet #60, *Voluntary Furlough Program.* (FOD #8418)

Fact Sheet #66, *SHBP Coverage for State Part-Time Employees.*

Fact Sheet #69, *SHBP Coverage for State Intermittent Employees.*

Fact Sheet #71, *Benefits Under the Domestic Partnership Act.* (FOD #8419)

Fact Sheet #73, *Retiree Dental Expense Plan.* (FOD #8257)

SHBP Member Handbooks

SHBP Traditional Plan Member Handbook

SHBP NJ PLUS Member Handbook

SHBP HMO member handbooks are available from the individual HMOs (see *SHBP Summary Program Description* for contact information).

SHBP Employee Prescription Drug Plan Member Handbook

SHBP Employee Dental Plans Member Handbook

SHBP Retiree Dental Expense Plan Member Handbook

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